High Levels of Cyclooxygenase-2 Expression are Associated with Prostate Cancer

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surgical treatment for urolithiasis between January 2010 and December 2011 allowing 5 year follow up.
Result: Preliminary data indicates no difference in stone size non-diabetic vs diabetic population; (11.9 mm vs. 12.7 mm, p=0.42). Diabetic patients included in our study were significantly older (65.6 vs 54, p=0.001) and on average had a worse kidney function with an eGFR (60 vs 68 p=0.11) and a serum creatinine of (103 vs 90, p =0.06). There was a greater proportion of diabetic patients with a positive pre-operative MSU (42% vs 19%, p=0.07). We identify 14 diabetics vs 85 non-diabetics who have appropriate follow up for one year, we find that diabetics are more likely to recur in one year than non-diabetics (46% vs 13%, p=0.04)

0775: REGULAR PSA TESTING IN GENERAL PRACTICE; DO WE SCREEN AGAINST CURRENT UROLOGY CONSENSUS?

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The Prostate Cancer Risk Management Programme supports an informed request for Prostate Specific Antigen(PSA) testing from asymptomatic men aged ≥50, while current consensus rejects screeing due to overdiagnosis and overtreatment. We audited current PSA-testing schedules and evaluated whether asymptomatic patients receive adequate pre-test counselling.
A cross-sectional analysis was done (EMIS Web database, Jul 2016) in a single practice of 7800 patients, including all patients with regular repeat PSA tests schedules (4-, 6- or 12-monthly). Indication, counselling, PSA levels, diagnosis, and secondary care input were evaluated.
78 men with a median age 71(range 49-88) were identified (29 Prostate Cancer, 24 Benign Prostatic Hypertrophy, 8 Unknown pathology, 7 Lower Urinary Tract Symptoms, 5 “Raised PSA”, 2 Hypogonadism, 1 High Risk Family History, 1 Overactive Bladder, 1 Chronic Prostatitis). Median initial PSA was 6.9 ng/ml (range 0.01-60). 5 patients were asymptomatic (Age ≥ 50) with no risk factors or known genitourinary pathology, but there was no identified informed decision. Hospital shared care protocols guided testing in 48 patients, with 5 patients accordingly referred back following PSA rise.
While the current practice of phlebotomy-led test scheduling is suitable for established pathological cases, a new patient pathway is needed to ensure adequate patient counselling in focused PSA 'screening'.

0810: FOLLOW UP OF PATIENTS WITH LOW RISK BLADDER CANCER IN A TERTIARY REFERRAL UROLOGY UNIT: DOES INTRODUCTION OF NICE GUIDANCE IMPROVE TIMELY DISCHARGE?

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Aim: To audit departmental practice of follow up of low risk bladder cancer patients following introduction of NICE guidance.
Method: Patients with low risk bladder cancer (as classified by NICE) undergoing follow up were identified using flexible cystoscopy lists over 2 months. An audit of follow up schedules was completed against NICE guidelines using clinic letters. A poster outlining the guidelines was displayed. After 3 months a re-audit was completed to assess change in practice. Data were analysed using Excell.
Result: 30/146 (20.5%) patients with non-muscle invasive bladder cancer were identified as low risk. 17/30 (57%) male and 13/30 (43%) female. Median age was 75.8yrs. Initial resection histology included 3/30 (10%) G1pTa and 17/30 (90%) G2pTa tumours. All were solitary and less than 3cm in size. 0/30 (0%) of patients had biomarkers of cytology used for follow up. 7/30 (23%) of patients were discharged to primary care after 12 months of follow up compared to 0/17 (0%) in the pre-intervention audit. 23/30 (76.5%) of patients were offered prolonged follow up compared to 17/17 (100%) pre-intervention.
Conclusion: Increasing departmental awareness of NICE guidance improved discharge rates and reduced numbers of patients having prolonged inappropriate flexible cystoscopy follow up.

0850: LAPAROSCOPIC OFF-CLAMP PARTIAL NEPHRECTOMY FOR RENAL TUMOURS WITH MODERATE TO HIGH R.E.N.A.L. NEPHROMETRY SCORES

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Aim: This study compares outcomes of Off-clamp partial nephrectomy (OCPN) relative to Hilar-clamp partial nephrectomy (HCPN) for renal lesions with moderate to high R.E.N.A.L. nephrometry scores.
Method: Demographic & perioperative data, and tumour complexity, calculated using the R.E.N.A.L. nephrometry scoring system, were collected for all laparoscopic partial nephrectomy procedures performed by a single surgeon between April 2014 and October 2016. OCPN cases with nephrometry scores of intermediate (score 7-9) and high-complexity (score 10-12) were compared against similarly scored HCPN cases. Adverse events, the perioperative eGFR and oncological results were analysed. The Exact Fischer and chi-square tests were used for statistical analyses.
Result: A total of 104 laparoscopic nephron-sparing procedures were performed. 47 patients with a low nephrometry score (0-6) were excluded. HCPN (n=17) were used as a comparator (mean 25 min warm ischaemia time). Estimated blood loss for OCPN (n=40) and HCPN was 260mls and 471mls respectively (p<0.05). There was no significant difference in terms of reduction in eGFR, conversion-to-open, perioperative nephrectomy, peri-operative urine leakage or positive margins.
Conclusion: OCPN appears to be a safe, effective and feasible option in the management of selected cases of complex renal masses. Longer follow up is needed to adequately assess the oncological outcome.

0920: SKILLS ACQUISITION TREND AND OUTCOMES FROM LAPAROSCOPIC TO ROBOTIC ASSISTED RADICAL CYSTECTOMY

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Aim: To decipher the outcomes during the transition phase from Laparoscopic Radical Cystectomy (LRC) and Robot-Assisted Radical Cystectomy (RARC) for Bladder Cancer (BC) using the template of a single experienced minimally invasive urological surgeon.
Method: The final 40 LRCs were compared with the first 40 RARCs. The 80 patients underwent their respective procedures between October 2013 and October 2016 at a tertiary uro-oncological centre. Data was retrospectively evaluated. We compared the different parameters such as cystectomy time, length of total hospital stay, lymph node dissection, resection margins, in-patient complications and 30-day re-admission. Data were analysed using SPSS Statistical Analysis Software.
Result: The median age for all patients is 70 (36 - 84), with median age of 71 (36 - 84) for RARCs and 70 (51 -82) for LRCs. Of total 80 patients, 62 (77.5%) were male and 18 (22.5%) were female. There were no significant differences in the rate of in-patient complications (p>1.00) and 30-day re-admission (p>0.05) between those who had RARCs and LRCs.
Conclusion: The transition from laparoscopic to robotic platform was not found to impact on cystectomy time, total length of hospital stay, lymph node dissection, resection margins, in-patient complications and 30-day re-admission rates. Current findings indicate the transition is safe.

0930: THE VALUE OF REPEAT DIPSTICK URINALYSIS: EXPERIENCES FROM AN ACUTE ADMISSIONS UNIT

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Background: Dipstick urinalysis is used to assess patients with urological symptoms in emergency settings. Onwards referrals can depend on the urinalysis results. At our hospital, patients referred from the emergency department (ED) to the surgical assessment unit (SAU) often have their urinalysis repeated. An audit was performed to determine if repeating the urinalysis was justified.
Method: Prospective data was collected over one month. 52 patients who had urinalysis performed in both departments were included and the results of their urine dips evaluated.